NAVIGATOR
by TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

> 2006 Benefit Update

Navigator By *Tufts Health Plan*™ Benefit Update (2006) GIC-NAVPPO-AMDMT-001 Ed. 7-2006

The information below amends or clarifies the language in the following documents for the Group Insurance Commission (GIC):

- The 2004 Navigator by *Tufts Health Plan*™ ("Navigator") *Member Handbook* (7-2004 edition); and
- The 2005 Navigator Benefit Update (7-2005 edition).

This Benefit Update describes revised benefits, benefit clarifications, and other important information about:

- your Medical and Prescription Drug Plan under the Navigator Plan administered by *Tufts Health Plan* ("*Tufts HP*"); and
- the Mental Health, Substance Abuse and EAP Program administered by United Behavioral Health (UBH).

You should put these pages in your 2004 Navigator *Member Handbook,* along with your 2005 Navigator Benefit Update for easy reference.

MEDICAL AND PRESCRIPTION DRUG PLAN - 2006 Updates

This section describes benefit clarifications and benefit revisions to your health care coverage under the Navigator Plan. These changes and revisions are effective as of July 1, 2006, unless otherwise indicated below.

Benefit Revisions:

•Navigator Plan *Inpatient Hospital Copayment* Levels

- The "Navigator *Inpatient Hospital* List" found in Part 11 (pages 10 and 75-78) of your 2004 Navigator *Member Handbook* and pages 4-7 of your 2005 Navigator Benefit Update has been revised. See pages 7-10 of this Benefit Update for the List in effect as of July 1, 2006.

- Effective July 1, 2006, the following three *Copayment* Levels apply to *Inpatient* admissions at *Tufts HP Hospitals* for *Obstetric Services*, and *Adult Medical and Surgical Services*:
  - *Copayment* Level 1 - $150 *Copayment* per admission* for *Tufts HP Hospitals* with the **best quality-cost scores**.
  - *Copayment* Level 2 - $300 *Copayment* per admission* for *Tufts HP Hospitals* with **better quality-cost scores**.
  - *Copayment* Level 3 - $500 *Copayment* per admission* for *Tufts HP Hospitals* with **good quality-cost scores**.

  *Subject to the *Inpatient* Care *Copayment* Maximum listed below.

- Effective July 1, 2006, the following two *Copayment* Levels apply to *Inpatient* admissions at *Tufts HP Hospitals* for *Pediatric Services*:
  - *Copayment* Level 1 – $200 *Copayment* per admission* for *Tufts HP Hospitals* with the **best quality-cost scores**.
  - *Copayment* Level 2 – $400 *Copayment* per admission* for *Tufts HP Hospitals* with **better quality-cost scores**.

  *Subject to the *Inpatient* Care *Copayment* Maximum listed below.

  All references in your 2005 Navigator Benefit Update to the three *Copayment* Levels for *Inpatient Pediatric Services* admissions at *Tufts HP Hospitals* (see pages 4-7 of your 2005 Navigator Benefit Update) are changed to reflect the two *Copayment* Levels.

• *Inpatient* Care *Copayment* Maximum (*In-Network Level of Benefits* only)

Effective July 1, 2006, the *Inpatient* Care *Copayment* Maximum will change from a maximum of one *Inpatient Copayment* per *Member* per calendar quarter to four *Inpatient Copayments* per *Member* per calendar year. All references to the *Inpatient* Care *Copayment* Maximum are changed to reflect this new policy.

- ***Outpatient* Office Visit *Copayments***

  Effective July 1, 2006, your *Copayments* for *Outpatient* office visits at the *In-Network Level of Benefits* will change. As a result of these changes, all references to the "Office Visit Copayment Maximum" in your 2004 Navigator Member Handbook and your 2005 Navigator Benefit Update are removed. Your *Copayments* will depend on the type of physician you see and on what hospital the physician has as his or her primary hospital affiliation.

  - If you seek care from a primary care physician (general practitioner, family practitioner, internal medicine specialist, pediatrician, primary care physician who is also a specialist, or obstetrician/gynecologist), a $15 *Copayment* will apply per visit.
  - If you seek care from a specialist practicing in any one of the following surgical specialties, and that specialist is primarily affiliated with a *Tufts HP Hospital* grouped in *Copayment* Level 1 for *Inpatient* Adult Medical/Surgery admissions, you will pay a $15 *Copayment* for *Outpatient* office visits:
    - colon and rectal surgery;
    - general surgery;
    - general vascular surgery;
    - hand surgery;
    - neurosurgery;
    - orthopedic surgery;
    - plastic and reconstructive surgery;
    - thoracic surgery;
    - urology.
  - A $25 *Copayment* will apply for *Outpatient* office visits with any other specialist.

  All references to *Copayments* for *Outpatient* office visits in your 2004 Navigator *Member Handbook* and your 2005 Navigator Benefit Update are changed to reflect these new *Copayments*.

- Effective July 1, 2006, there will no longer be an Office Visit *Copayment* Maximum for *Outpatient* office visits at the *In-Network Level of Benefits*. You will be required to pay a *Copayment* for all *Outpatient* office visits that are subject to a *Copayment*. As a result of this change, all references to the "Office Visit Copayment Maximum" in your 2004 Navigator Member Handbook and your 2005 Navigator Benefit Update are removed.

- **Early Intervention Services**

Effective July 1, 2006, the benefit limit for early intervention services has been changed. Early intervention services will now be covered up to $5,200 per *Member* per calendar year, up to a lifetime maximum of $15,600 per *Member*. As a result of this change, the "Early intervention services" benefit listed in the "*Outpatient* care" section in the "Benefit Overview" on page 11 of your 2004 Navigator *Member Handbook* now appears as follows:

Covered Services	***In-Network***	***Out-of-Network***
	***Member's* Cost**	***Member's* Cost**
Early intervention services ☞ Page 36	**Covered up to a total of $5,200 per *Member* each calendar year ($15,600 lifetime) (*In-Network* and *Out-of-Network Levels* combined)**	
	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

In addition, the "Note" following the benefit description for "Early intervention services for a *Dependent Child*" on page 36 of the 2004 Navigator *Member Handbook* has been changed to read as follows:

Note: Early intervention services are covered up to a total of $5,200 per *Member* per calendar year, and a lifetime maximum of $15,600 per *Member*.

- **Diagnostic Imaging**

Effective July 1, 2006, prior approval may be required for MRI/MRA, CT/CTA, PET, and nuclear medicine. As a result of this change, the "Diagnostic Imaging" benefit listed on page 8 of your 2005 Navigator Benefit Update, which modified page 12 of your 2004 Navigator *Member Handbook*, is changed to read as follows:

Covered Services	***In-Network***	***Out-of-Network***
	***Member's* Cost**	***Member's* Cost**
Diagnostic imaging • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET and nuclear medicine **(AR)** ☞ Page 38	General imaging: Covered in full. MRI/MRA, CT/CTA, PET, and nuclear medicine: Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

In addition, the following "Important Note" has been added to the benefit description for "Diagnostic Imaging" (see page 8 of your 2005 Navigator Benefit Update):

Important Note: Prior authorization may be required for MRI/MRA, CT/CTA, PET and nuclear medicine. Please call Member Services for more information.

- ***Day Surgery***

  For purposes of clarification, certain *Day Surgery* services require review and approval by an *Authorized Reviewer* in order to be considered *Covered Services*. Therefore, the *Day Surgery* benefit listed on page 13 in "Part 1 – Benefit Overview" of your 2004 Navigator *Member Handbook* now appears as follows:

Covered Services	***In-Network***	***Out-of-Network***
	***Member's* Cost**	***Member's* Cost**
Day Surgery:		
Day Surgery **(AR)** ☞ Page 40	$75 *Copayment* per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described on page 10 above.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

- **Extended Care Facility Services – Services in a Skilled Nursing Facility**

  Effective July 1, 2006, *Covered Services* in a skilled nursing facility will no longer be covered in full at the *In-Network Level of Benefits*. Instead, for covered facility and physician services in a skilled nursing facility, you will be required to pay 20% of the *Reasonable Charge* at the *In-Network Level of Benefits.* (Covered extended care facility services provided in a rehabilitation hospital or chronic care hospital will continue to be covered in full at the *In-Network Level of Benefits*.) In addition, there will no longer be a $10,000 limit per *Member* per calendar year in a skilled nursing facility. Instead, you will be limited to 45 days of skilled nursing facility services per *Member* per calendar year (*In-Network* and *Out-of-Network Levels* combined). In addition, if you receive services in a skilled nursing facility at the *Out-of-Network Level of Benefits*, the costs for those services will not count towards the *Out-of-Network Out-of-Pocket Maximum*. As a result of these changes, the "services in a skilled nursing facility" benefit listed under "Extended Care Facility Services" in the "Other Health Services" section on page 16 of the "Benefit Overview" in the 2004 Navigator *Member Handbook* is changed to read as follows:

Covered Services	***In-Network***	***Out-of-Network***
	***Member's* Cost**	***Member's* Cost**
Extended care facility service: **(AR)**		
• provided in a skilled nursing facility	20% of the *Reasonable Charge* (plus any balance)	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
• provided in a rehabilitation hospital or chronic hospital ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
• **Covered facility and physician services provided in a skilled nursing facility are limited to 45 days per *Member* per calendar year (*In-Network* and *Out-of-Network Levels* combined).** • **The cost of services provided in a skilled nursing facility at the *Out-of-Network Level of Benefits* cannot be used to satisfy the *Member's Out-of-Network Out-of-Pocket Maximum*.** • ***Preregistration* is required prior to any *Out-of-Network* admission, or the *Member* must pay a $500 *Preregistration Penalty* (see pages 27-29).**		

  In addition, the "Note" following the "Extended Care" benefit description (see Part 5, page 43, of your 2004 Navigator *Member Handbook*) has been changed to read as follows:

  Note: *Covered* facility and physician services for extended care provided in a skilled nursing facility are limited to a total of 45 days per *Member* in a calendar year (*In-Network* and *Out-of-Network Levels* combined).

- **Spinal manipulation**

  Effective July 1, 2006, coverage for an initial spinal manipulation evaluation will be limited to one evaluation per calendar year. This evaluation is not part of the 20 visit limit for spinal manipulation. Due to this change, the "Spinal manipulation" benefit listed in the "Other Health Services" section of the "Benefit Overview" on page 17 of your 2004 Navigator *Member Handbook* now appears as follows:

Covered Services	***In-Network***	***Out-of-Network***
	***Member's* Cost**	***Member's* Cost**
Spinal manipulation ☞ Page 47	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
	Limited to a total of one spinal manipulation evaluation and 20 visits per calendar year (*In-Network* and *Out-of-Network Levels* combined).	

  In addition, the "Note" following the "Spinal manipulation" benefit on page 47 of your 2004 Navigator *Member Handbook* has been changed to reflect this clarification, as follows:

  Note: Benefits for *Covered* spinal manipulation services are limited to one spinal manipulation evaluation and a total of 20 spinal manipulation visits per *Member* in a calendar year (*In-Network* and *Out-of-Network Levels* combined).

- **Prescription Drug Benefit**
  - Effective July 1, 2006, your Tier-3 prescription drug *Copayment*s will increase. In addition, you will no longer be able to purchase 60- and 90-day supplies of medications at a retail pharmacy. Also effective July 1, 2006, when your physician prescribes a brand-name drug that has a generic equivalent, you will receive the generic drug and pay the applicable Tier *Copayment*. However, if your physician requests that you receive a covered brand-name drug only, you will pay the *Copayment* applicable to the generic drug plus the difference between the cost of the generic drug and the cost of the covered brand-name drug.
  - Due to these changes, the "Prescription Drug Coverage Table" found on page 48 of your 2004 Navigator *Member Handbook* will now appear as follows:

PRESCRIPTION DRUG COVERAGE TABLE	
Description	**Coverage**
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a *Tufts HP* designated retail pharmacy.	**Tier-1 drugs (many generic drugs are on Tier-1):** $10 *Copayment* for up to a 30-day supply **Tier-2 drugs:** $20 *Copayment* for up to a 30-day supply **Tier-3 drugs:** $40 *Copayment* for up to a 30-day supply*
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through the *Tufts HP* designated mail services pharmacy.	**Tier-1 drugs (many generic drugs are on Tier-1):** $20 *Copayment* for up to a 90-day supply **Tier-2 drugs:** $40 *Copayment* for up to a 90-day supply **Tier-3 drugs:** $90 *Copayment* for up to a 90-day supply*
*Important Note: When your physician prescribes a brand-name drug that has a generic equivalent, you will receive the generic drug and pay the applicable Tier *Copayment*. However, if your physician requests that you receive a covered brand-name drug only, you will pay the *Copayment* applicable to the generic drug plus the difference between the cost of the generic drug and the cost of the covered brand-name drug.	

- Effective January 1, 2006, the list of "Non-Covered Drugs with Suggested Alternatives" found in Part 10 (pages 73-74) of your 2004 Navigator *Member Handbook* and on pages 2-3 of your 2005 Navigator Benefit Update has been changed to read as follows:

Part 10 – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2006 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter.

IMPORTANT NOTE: Please see the *Plan's* Web site at **www.tuftshealthplan.com** for the most current list or call a Member Services Coordinator.

Brand Name	Suggested Alternatives
Abilify solution	Abilify tablets (Tier 2, middle *Copayment*)
AcipHex	Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest *Copayment*), Nexium or Prevacid (Tier-3, highest *Copayment*)
Ambien CR	Ambien or Sonata (Tier-2, middle *Copayment*); Lunesta (Tier-3, highest *Copayment*)
Atacand	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Atacand HCT	Benicar HCT, Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Avalide	Benicar HCT, Diovan HCT, or Hyzaar (Tier-3, highest *Copayment*)
Avapro	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Axid	cimetidine, famotidine, nizatidine, or ranitidine (Tier-1, lowest *Copayment*)
Beconase AQ	Nasacort AQ, Flonase, Nasonex, or Rhinocort Aqua (Tier-2, middle *Copayment*)
BiDil	Isosorbide dinitrate and hydralizine (Tier 1, lowest *Copayment*)
Bright Beginnings Prenatal Supplement Bars	prenatal vitamins plus iron (Tier-1, lowest *Copayment*)
Capoten	captopril (Tier-1, lowest *Copayment*)
Clarinex	loratidine (OTC, not covered); fexofenadine (Tier 1, lowest *Copayment*) or Zyrtec (Tier-3, highest *Copayment*)
Dynacin	minocycline hcl capsules (Tier-1, lowest *Copayment*)
EC Naprosyn	enteric-coated naproxen (Tier-1, lowest *Copayment*)
Evoclin	clindamycin phosphate 1% lotion (Tier-1, lowest *Copayment*)
Flagyl, Flagyl ER	metronidazole tabs (Tier-1, lowest *Copayment*)
Genotropin	Humatrope, Norditropin, Nutropin, Protropin, Saizen (Tier-2, middle *Copayment*)
Klonopin	clonazepam (Tier-1, lowest *Copayment*)
Lagesic	Aceta-Gesic (OTC, not covered)
Lidex, Lidex-E	fluocinonide and fluocinonide E (Tier-1, lowest *Copayment*)
Lopressor	metoprolol (Tier-1, lowest *Copayment*)
Lupron 1mg/0.2mL vial and kit	leuprolide 1mg/0.2mL vial and kit (Tier-1, lowest *Copayment*)
Megace ES	megestrol acetate oral suspension (Tier-1, lowest *Copayment*)
Mevacor	lovastatin (Tier-1, lowest *Copayment*)
Micardis	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Micardis HCT	Benicar HCT, Diovan HCT and Hyzaar (Tier-3, highest *Copayment*)
Minocin	minocycline hcl capsules (Tier-1, lowest *Copayment*)
Monodox	doxycyline monohydrate (Tier-1, lowest *Copayment*)
Myrac	minocycline tablets (Tier-1, lowest *Copayment*)
Naprelan	naproxen sodium extended-release (Tier-1, lowest *Copayment*)
Niravam	alprazolam (Tier-1, lowest *Copayment*)
Pepcid (except suspension)	cimetidine, famotidine, nizatidine, or ranitidine (Tier-1, lowest *Copayment*)

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Appendix B – Non-Covered Drugs With Suggested Alternatives – continued

Brand Name	Suggested Alternatives
Prevacid Naprapac	naproxen (Tier-1, lowest *Copayment*) plus Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest *Copayment*), Nexium or Prevacid (Tier-3, highest *Copayment*)
Prilosec	Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest *Copayment*), Nexium and Prevacid (Tier-3, highest *Copayment*) PLEASE NOTE: Prilosec is covered for Members 12 years of age and younger (Tier-3, highest *Copayment*)
Prinivil	lisinopril (Tier-1, lowest *Copayment*)
Prinzide	lisinopril/hydrochlorothiazide (Tier-1, lowest *Copayment*)
Reprexain	hydrocodone/ibuprofen (Tier-1, lowest *Copayment*)
Rozerem	Ambien or Sonata (Tier-2, middle *Copayment*), Lunesta (Tier-3, highest *Copayment*)
Sporanox capsules (itraconazole)	Lamisil tablets (prior authorization required) (Tier-3, highest *Copayment*)
Teveten	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Teveten HCT	Benicar HCT, Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Valium	diazepam (Tier-1, lowest *Copayment*)
Vasotec	enalapril (Tier-1, lowest *Copayment*)
Vicoprofen	hydrocodone/ibuprofen (Tier-1, lowest *Copayment*)
Xanax/Xanax XR	alprazolam (Tier-1, lowest *Copayment*)
Zegerid	Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest *Copayment*), Nexium or Prevacid (Tier-3, highest *Copayment*)

- ***Out-of-Pocket Maximum* (*Out-of-Network Level of Benefits* only)**

Effective July 1, 2006, the "Note" in this provision (see Part 2, page 20 in your 2004 Navigator *Member Handbook*), describing services that cannot be used to satisfy the *Out-of-Network Out-of-Pocket Maximum*, is revised to include the following Item 8:

8. Any amount you pay for extended care facility services provided in a skilled nursing facility.

- **Navigator Plan *Inpatient* Hospital *Copayment* Levels**

  Effective July 1, 2006, the "Navigator *Inpatient Hospital* List" found in Part 11 (pages 75-78) of your 2004 Navigator *Member Handbook* and on pages 4-7 in your 2005 Navigator Benefit Update has been revised to read as shown below. In addition, please note that the Navigator Plan *Inpatient Hospital Copayment* Levels are available by calling Member Services or on the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

Part 11– Navigator Plan *Inpatient Hospital Copayment* Levels - continued

Under the Navigator Plan, *Copayments* for *Inpatient* hospital stays at *Tufts HP Hospitals* for *Obstetric Services* and *Adult Medical and Surgical Services* are grouped into three *Inpatient Hospital Copayment* Levels, which are based upon the **quality-cost score** for each of these services. (You can call Member Services for more information about hospital groupings.)

- *Tufts HP Hospitals* with the **best quality-cost scores** are grouped in ***Copayment* Level 1**. *Inpatient Obstetric Services* and *Adult Medical and Surgical Services* at a *Tufts HP Hospital* included in *Copayment* Level 1 are subject to **a $150 *Copayment*** per admission*.
- *Tufts HP Hospitals* with **better quality-cost scores** are grouped in ***Copayment* Level 2**. *Inpatient Obstetric Services,* and *Adult Medical and Surgical Services* at a *Tufts HP Hospital* included in *Copayment* Level 2 are subject to **a $300 *Copayment*** per admission*.
- *Tufts HP Hospitals* with **good quality-cost scores** are grouped in ***Copayment* Level 3**. *Inpatient Obstetric Services* and *Adult Medical and Surgical Services* at a *Tufts HP Hospital* included in *Copayment* Level 3 are subject to **a $500 *Copayment*** per admission*.

*Subject to the *Inpatient* Care *Copayment* Maximum listed in the "*Inpatient* Care *Copayment* Maximum" provision on page 1 of this 2006 Navigator Benefit Update.

Copayments for *Inpatient* hospital stays at *Tufts HP Hospitals* for *Pediatric Services* are grouped into two *Inpatient Hospital Copayment* Levels, which are based upon the **quality-cost score** for these services. (You can call Member Services for more information about hospital groupings.)

- *Tufts HP Hospitals* with the **best quality-cost scores** are grouped in ***Copayment* Level 1**. *Inpatient Pediatric Services* at a *Tufts HP Hospital* included in *Copayment* Level 1 are subject to **a $200 *Copayment*** per admission*.
- *Tufts HP Hospitals* with **better quality-cost scores** are grouped in ***Copayment* Level 2**. *Inpatient Pediatric Services* at a *Tufts HP Hospital* included in *Copayment* Level 2 are subject to **a $400 *Copayment*** per admission*.

*Subject to the *Inpatient* Care *Copayment* Maximum listed in the "*Inpatient* Care *Copayment* Maximum" provision on page 1 of this 2006 Navigator Benefit Update.

Important Note:

These *Copayment* Levels do not apply to:

- specialized hospitals (including the Massachusetts Eye and Ear Infirmary, the New England Baptist Hospital, or the Dana Farber Cancer Institute);
- *Tufts HP Hospitals* with fewer than 100 admissions per year for *Obstetric Services and Pediatric Services;* or
- *Tufts HP Hospitals* located outside of Massachusetts.

Your *In-Network* care at these *Tufts HP Hospitals* is subject to a $300 *Copayment* per admission (subject to the *Inpatient* Care *Copayment* Maximum listed in the "*Inpatient* Care *Copayment* Maximum" provision on page 1 of this 2006 Navigator Benefit Update).

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There are other *In-Network* services for which the *Inpatient* Hospital *Copayment* Levels do not apply. These include:

- Services for newborn *Children* who stay in the hospital beyond the mother's discharge. **These services are covered in full.**
- Covered transplants for *Members* at the *Plan's In-Network* Transplant Centers of Excellence **are subject to a $150 *Copayment* per admission***. Any additional *Inpatient* admission to an *In-Network Hospital* for *Covered Services* related to the transplant procedure(s) is subject to the applicable *Inpatient Hospital Copayment* in the "Navigator *Inpatient Hospital Copayment* List." Please see pages 10-12 of this 2006 Navigator by *Tufts Health Plan* Update for those *Copayment* amounts in effect as of July 1, 2006.

* Subject to the *Inpatient* Care *Copayment* Maximum listed in the "*Inpatient* Care *Copayment* Maximum" provision on page 1 of this 2006 Navigator Benefit Update.

The Navigator *Inpatient Hospital Copayment* List, which appears in the following table, lists *Hospitals* and the applicable *Copayments* for:

- *Inpatient Obstetric Services*,
- *Pediatric Services*, and
- *Adult Medical and Surgical Services*.

- **Navigator Plan *Inpatient Hospital Copayment* Levels – continued**

Massachusetts

Region	*Hospital*	*Obstetrical Care Copayment*	*Pediatric Care Copayment*	*Adult Medical/Surgical Care Copayment*
East	Addison Gilbert Hospital	$300 (NL*)	$400 (NL*)	$300
	Anna Jaques Hospital	$500	$400	$300
	Beth Israel Deaconess Hospital – Needham	$300 (NL*)	$400 (NL*)	$300
	Beth Israel Deaconess Medical Center	$300	$400 (NL*)	$300
	Beverly Hospital	$500	$400	**$150**
	Boston Medical Center	$500	$**200**	$300
	Brigham and Women's Hospital	$300	$400 (NL*)	$300
	Brockton Hospital	**$150**	$400	$300
	Cambridge Hospital	$300	$400	$500
	Cape Cod Hospital	**$150**	$400	**$150**
	Caritas Carney Hospital	$300 (NL*)	$$400	$300
	Caritas Good Samaritan Medical Center	**$150**	$400 (NL*)	**$150**
	Caritas Holy Family Hospital	$500	$400	$300
	Caritas Norwood Hospital	$500	$400	$300
	Caritas St. Elizabeth's Medical Center	$500	$400 (NL*)	$300
	Charlton Memorial Hospital	$300	$400 (NL*)	$300
	Children's Hospital	$300 (NL*)	$400	$300 (NL*)
	Dana-Farber Cancer Institute	$300 (NL*)	$400 (NL*)	$300 (NL*)
	Emerson Hospital	$500	$400	$500
	Falmouth Hospital	**$150**	$400	**$150**
	Faulkner Hospital	$300 (NL*)	$400 (NL*)	**$150**
	Jordan Hospital	**$150**	$400	$500
	Lahey Clinic Hospital	$300 (NL*)	$400 (NL*)	$300
	Lawrence General Hospital	**$150**	**$200**	$300
	Lawrence Memorial Hospital (Hallmark Health Systems)	$300 (NL*)	$400 (NL*)	$300
	Lowell General Hospital	$300	**$200**	**$150**
	Massachusetts Eye and Ear Infirmary	$300 (NL*)	$400 (NL*)	$300 (NL*)
	Massachusetts General Hospital	$300	$400	$500
	Melrose Wakefield Hospital (Hallmark Health Systems)	$300	$400 (NL*)	$300
	Merrimack Valley Hospital	$300 (NL*)	$400 (NL*)	**$150**
	Metrowest Medical Center – Framingham	**$150**	$400	$300
	Metrowest Medical Center- Leonard Morse	$300 (NL*)	$400 (NL*)	$300

NL* These *Hospitals* are not grouped in a *Copayment* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of Tufts HP's network of *Providers* listed above are in effect as of July 1, 2006. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

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- **Navigator Plan *Inpatient Hospital Copayment* Levels – continued**

Massachusetts - continued

Region	*Hospital*	*Obstetrical Care Copayment*	*Pediatric Care Copayment*	*Adult Medical/Surgical Care Copayment*
East, *continued*	Milton Hospital	$300 (NL*)	$400 (NL*)	$300
	Morton Hospital and Medical Center	$300	$400	**$150**
	Mount Auburn Hospital	**$150**	$400 (NL*)	$300
	New England Baptist Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)
	Newton-Wellesley Hospital	**$150**	$400	**$150**
	Quincy Medical Center	$300 (NL*)	$400 (NL*)	$300
	Saints Memorial Medical Center	$300	$400 (NL*)	**$150**
	Salem Hospital (North Shore Medical Center)	$300	$400	$300
	South Shore Hospital	$300	**$200**	**$150**
	St. Anne's Hospital	$300 (NL*)	**$200**	$300
	St. Luke's Hospital	$300	$400	$300
	Sturdy Memorial Hospital	$300	$400	$500
	Tobey Hospital	$300	$400	$500
	Tufts New England Medical Center	$500	**$200**	$300
	Union Hospital (North Shore Medical Center)	$300 (NL*)	$400 (NL*)	$300
	Winchester Hospital	**$150**	**$200**	**$150**
Central	Athol Memorial Hospital	$300 (NL*)	$400 (NL*)	$500
	Clinton Hospital	$300 (NL*)	$400 (NL*)	$500
	Harrington Hospital	$500	$400	$500
	HealthAlliance Hospital	$300	$400	**$150**
	Henry Heywood Hospital	$300	$400	$300
	Hubbard Regional Hospital	$300 (NL*)	$400 (NL*)	$500
	Marlborough Hospital	$300 (NL*)	$400 (NL*)	$300
	Milford Regional Medical Center	$500	$400	$500
	Nashoba Valley Medical Center	$300 (NL*)	$400 (NL*)	$300
	St. Vincent Hospital	$300	$400	$300
	UMass Memorial Medical Center	**$150**	**$200**	$300

NL* These *Hospitals* are not grouped in a *Copayment* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of Tufts HP's network of *Providers* are in effect as of July 1, 2006. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

(continued on next page)

- **Navigator Plan *Inpatient Hospital Copayment* Levels – continued**

Massachusetts - continued

Region	*Hospital*	*Obstetrical Care Copayment*	*Pediatric Care Copayment*	*Adult Medical/Surgical Care Copayment*
West	Baystate Medical Center	$300	**$200**	**$150**
	Berkshire Medical Center	**$150**	**$200**	**$150**
	Cooley Dickinson Hospital	**$150**	$400	$500
	Fairview Hospital	$500	$400 (NL*)	$500
	Franklin Medical Center	**$150**	$400 (NL*)	$300
	Holyoke Hospital	$500	$400 (NL*)	$300
	Mary Lane Hospital	$500	$400 (NL*)	**$150**
	Mercy Medical Center	**$150**	$400 (NL*)	**$150**
	Noble Hospital	$300 (NL*)	$400 (NL*)	**$150**
	North Adams Regional Hospital	$500	$400	$500
	Wing Memorial Hospital	$300 (NL*)	$400 (NL*)	**$150**

New Hampshire

Catholic Medical Center	$300 (NL*)	$400 (NL*)	$300 (NL*)
Elliot Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)
Mary Hitchcock Memorial	$300 (NL*)	$400 (NL*)	$300 (NL*)
Parkland Medical Center	$300 (NL*)	$400 (NL*)	$300 (NL*)
Southern N.H. Regional Medical Center	$300 (NL*)	$400 (NL*)	$300 (NL*)
St. Joseph Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)

Rhode Island

Kent County Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)
Landmark Medical Center	$300 (NL*)	$400 (NL*)	$300 (NL*)
Memorial Hospital of RI	$300 (NL*)	$400 (NL*)	$300 (NL*)
Miriam Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)
Newport Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)
Rhode Island Hospital – including Hasbro Children's Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)
Roger Williams Medical Center	$300 (NL*)	$400 (NL*)	$300 (NL*)
St. Joseph's Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)
Women and Infants Hospital	$300 (NL*)	$400 (NL*)	$300 (NL*)

NL* These *Hospitals* are not grouped in a *Copayment* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of Tufts HP's network of *Providers* are in effect as of July 1, 2006. For the most up-to-date status, please contact *Member Services* at 1-800-870-9488.

Benefit Clarifications:

- **Benefits requiring *Authorized Reviewer* approval**

  For purposes of clarification, certain *Day Surgery* services require review and approval by an *Authorized Reviewer* in order to be considered *Covered Services*. Therefore, the *Day Surgery* benefit listed in your 2004 Navigator *Member Handbook* is changed to note this requirement.

  The following bulleted item is thus added to the "Note" following the "*Day Surgery*" benefit description (see page 40 of your 2004 Navigator *Member Handbook* and the "*Day Surgery*" item listed on page 9 of your 2005 Navigator Benefit Update):

  - Prior approval by an *Authorized Reviewer* is required for certain *Day Surgeries* at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on page 34 of your 2004 Navigator *Member Handbook* for more information about which *Day Surgeries* require this approval and about when you are responsible for obtaining this approval.

- **Family Planning Procedures, Services, and Contraceptives**

  For purposes of clarification, the second bullet in the "Notes" under "Contraceptives", in Part 5, page 36 of your 2004 Navigator *Member Handbook*, has been removed. Depo-Provera is not covered under your Prescription Drug Benefit under any circumstances; it is instead covered under this "Family Planning Procedures, Services, and Contraceptives" benefit.

- **Reconstructive surgery and procedures**

  This benefit (see page 42 in your 2004 Navigator *Member Handbook* and page 11 of your 2005 Navigator Benefit Update) is clarified with respect to coverage for the removal of breast implants. As a result of this clarification, the section of the benefit discussing the removal of breast implants now reads as follows:

  Removal of breast implants is covered when any one of the following conditions exists:
  - the implant was placed post-mastectomy;
  - there is documented rupture of a silicone implant; or
  - there is documented evidence of autoimmune disease.

  Important: No coverage is provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

- ***Durable Medical Equipment***

  For purposes of clarification, the following item is added to the "Examples of covered items" section in the "*Durable Medical Equipment*" benefit (see Part 5, page 45 in your 2004 Navigator *Member Handbook*:

  - Scooters and power/electric wheelchairs;

  For purposes of clarification, the following items are added to "Examples of excluded items" section in the "*Durable Medical Equipment*" benefit (see Part 5, page 45 in your 2004 Navigator *Member Handbook* and page 11 of your 2005 Navigator Benefit Update):
  - bed related items, including, but not limited to, bed trays, over- the- bed tables, and bed wedges;
  - fixtures to real property: ceiling lifts, elevators, ramps, stair climbers;
  - car/van modifications;
  - saunas;
  - manual breast pumps;
  - mattresses, except for mattresses used in conjunction with a hospital bed and ordered by a physician. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g., Tempur-Pedic® and Posturepedic® mattresses) are not covered;

- **Injectable Medications**

  For purposes of clarification, the "Injectable medications" benefit (see Part 5, page 45, in your 2004 Navigator *Member Handbook*) has been reworded and now reads as follows:

  Coverage is provided for injectable medications that are required for and are an essential part of an office visit to diagnose and treat illness or injury.

  Notes:

  - Prior authorization and dispensing limits may apply.
  - Medications that are listed on the *Tufts HP* Web site as covered under a *Tufts HP* pharmacy benefit are not covered under this "Injectable medications" benefit. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

- **Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients**

  This benefit (shown on page 46 in your 2004 Navigator *Member Handbook*) has been renamed "Scalp hair prostheses or wigs." In addition, the benefit description has been changed to include coverage for alopecia areata and alopecia totalis, and now reads as follows:

  Scalp hair prostheses or wigs

  Coverage is provided for:

  - scalp hair prostheses made specifically for an individual, or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury.
  - scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.

  Note: *Covered Services* for these prostheses and wigs are limited to a total of $350 per *Member* in a calendar year (*In-Network* and *Out-of-Network Levels* combined).

- **Prescription Drug Benefit**

  - Coverage for drugs obtained at a retail pharmacy is now limited to a 30-day supply. Please see page 5 of this 2006 Navigator by *Tufts Health Plan* Benefit Update for more information.

  - For purposes of clarification, the bulleted item describing coverage for "oral contraceptives, diaphragms, and Depo-Provera" under the "What is Covered" section (see Part 5, page 51 in your 2004 Navigator *Member Handbook,* the "Prescription Drug Benefit" on page 11 of your 2005 Navigator Benefit Update, and "Family Planning Procedures, Services, and Contraceptives" on page 13 of this 2006 Navigator Benefit Update) is changed to read as follows:

    - Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law*.

      *Note: This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law. See "Family planning" on page 36 in your 2004 Navigator *Member Handbook* for information about other contraceptive drugs and devices that qualify as *Covered Services*.

  - The following bulleted item is added to the "What is Not Covered" section (see Part 5, page 50 in your 2004 Navigator *Member Handbook*):

    - medications for the treatment for idiopathic short stature;

- **Exclusions from Benefits**

  For purposes of clarification, the following changes have been made to the "Exclusions from Benefits" section (see Part 5, page 55 in your 2004 Navigator *Member Handbook* and page 12 of your 2005 Navigator Benefit Update):

  - The exclusion relating to foot care has been revised to address routine foot care coverage for *Members* diagnosed with diabetes. The exclusion now reads as follows:

    Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. The exclusion for routine foot care does not apply to *Members* diagnosed with diabetes.

    Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:

    - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
    - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.

• The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The above referenced provision has been added to Part 6 of your Navigator *Member Handbook* and reads as follows:

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your *Dependents* while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.
- Service members who elect to continue their GIC health coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the *Commission.*

• Terms and Definitions

The following changes have been made to the "Terms and Definitions" section (see Part 9, pages 66-72 in your 2004 Navigator *Member Handbook*):

- For purposes of clarification, the second paragraph of the *Out-of-Pocket Maximum* definition on page 70 is changed to read as follows:

  An Out-of-Pocket Maximum:

  - consists of the *Deductible* and *Coinsurance*; and
  - does not include any *Copayments*, Preregistration Penalties, costs for health care services that are not *Covered Services*, or services or supplies listed in the "Note" for the "*Out-of-Pocket Maximum*" provision on page 20 (as amended on page 7 of your 2006 Navigator Benefit Update).

MENTAL HEALTH, SUBSTANCE ABUSE AND EAP PROGRAM

This section describes changes to your coverage under the Mental Health, Substance Abuse, and EAP Programs.

2006 BENEFIT UPDATE

The following information is provided as a clarification to the information found in your Navigator Member Handbook.

This Benefit Update is effective as of July 1, 2006.

As a reminder, your member handbook and benefit update clarifications provide you with a "Description of Benefits" for your mental health, substance abuse and EAP services. While it is a full description of the available benefits under this plan, it is not the "Evidence of Coverage," the legal policy document that UBH submits to the Massachusetts Division of Insurance (DOI). The "Evidence of Coverage" governs the plan and includes state and federal mandated language, required disclosures to the Office of Patient Protection, continuation of coverage provisions as directed by state and federal law, and other required plan disclosures. The full "Evidence of Coverage" is available in electronic form and can be downloaded from the UBH website www.liveandworkwell.com (access code: 10910). If you would prefer a paper copy of this document please send a written request to UBH at the address provided on page 82 of your 2004 Navigator Member Handbook, and a copy will be sent to you free of charge.

United Behavioral Health Mental Health, Substance Abuse and Enrollee Assistance Programs

Part II – Benefit Chart: Outpatient Care

Please replace the **Outpatient Care** *benefit chart found on pages 87-88 in its entirety with the following summary chart. Be sure to read Part III which describes your benefits in detail and notes some important restrictions.*

Outpatient Care (a) ***Covered Service***	**Network Benefits**	**Out-of-Network Benefits**
Individual and family therapy Medication Management: 15-30 minute psychiatrist visit Group Therapy	100%, after $15 per visit 100%, after $10 per visit 100%, after $10 per visit	First 15 visits: 80% per visit Visits 16 and over: 50% per visit (c)
	Network costs paid by member count towards *out-of-pocket maximum*	Out-of-Network care utilized to satisfy the annual deductible counts toward the first 15 visits. Out-of-Network costs paid by member do not count toward *out-of-pocket maximum*
Enrollee Assistance Program	Up to 3 visits: 100%	No Coverage for EAP
In-Home Mental Health Care	Full Coverage	First 15 visits: 80% per visit Visits 16 and over: 50% per visit
Drug Testing (as an adjunct to Substance Abuse Testing)	Full Coverage	No Coverage
Provider Eligibility - provider must be an independently licensed mental health professional in one of these disciplines.	MD Psychiatrist, PhD, EdD, MSW, MSN, LICSW, RNMSCS, MA (b)	MD Psychiatrist, PhD, EdD, MSW, MSN, LICSW, RNMSCS, MA (b)

(a) Treatment that is not precertified receives Out-of-Network reimbursement.

(b) Massachusetts independently licensed providers; psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied health professionals.

(c) Out-of-Network outpatient visits 16 and over are subject to the same precertification requirements as Network benefits in order to be eligible for coverage.

Part III – Benefits Explained

Please replace the ***Outpatient Care*** paragraph of the section titled "Network Benefits" in its entirety on page 89 of your 2004 Navigator Member Handbook with the following:

Network Benefits

Outpatient Care – The *copayment* schedule for network outpatient covered services is shown below:

Individual and family therapy, all visits	$15 *copayment*
Medication Management, all visits	$10 *copayment*
Group therapy, all visits	$10 *copayment*
Enrollee Assistance Program, Up to 3 visits	No *copayment*

Outpatient care no longer *cross accumulates* with EAP services. (See pages 91-92 of your 2004 Navigator Member Handbook for a full explanation of EAP services.) All outpatient mental health and substance abuse services now have a copay.

Failure to *precertify* outpatient care results in a benefit reduction to the Out-of-Network benefit level.

Please note that the **Substance Abuse Rehabilitation Incentive Program** *described on page 89 of your Navigator Member Handbook is no longer available.*

Important Notice
About Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this NOTICE OF CREDITABLE COVERAGE be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and the new Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS', SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

The New Medicare Drug Plans

The new Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans might also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan, Harvard Pilgrim Health Care First Seniority or Tufts Health Plan Medicare Preferred (formerly Secure Horizons), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage will pay. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. After May 15, 2006, if your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.medicare.gov.
- Call the Group Insurance Commission at 1-617-727-2310.

Notice of Group Insurance Commission Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures
We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures:
The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals);
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements;
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive a separate paper copy of this notice upon request. (an electronic version of this notice is on our website at www.mass.gov/gic.

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 801 or TTY for the deaf and hard of hearing at (617)-227-8583.

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

1-800-870-9488

For the Enrollee Assistance Program or
Mental Health or Substance Abuse treatment,
please call United Behavioral Health

1-888-610-9039

NAVIGATOR
by TUFTS Health Plan

Tufts Health Plan
333 Wyman Street, P.O. Box 9112
Waltham, MA 02454-9112

For additional information,
please call 1-800-870-9488

www.tuftshealthplan.com

Offered by Tufts Benefit Administrators, Inc.
Tufts Health Plan reserves the right to add to, change, or withdraw the services described in this booklet at any time.

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